The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure

Board of Registration in Pharmacy
239 Causeway Street, Suite 200, 2nd Floor
Boston, MA 02114
(800) 414-0168 (office) / 617-973-0983 (fax)
http://www.mass.gov/reg/boards/ph

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

TIMOTHY R. MURPHY
SECRETARY

PAUL J. COTE, JR.
COMMISSIONER

JEAN K. PONTIKAS
DIRECTOR

**APPLICATION FOR A CHANGE IN MANAGER OF A PHARMACY OR PHARMACY DEPARTMENT**

(1) Whenever there is a change in the pharmacist Manager of Record of a pharmacy or pharmacy department, an application for a change in pharmacist Manager of Record shall be obtained from and promptly submitted to the Board. A completed application shall be fully and properly completed and signed, under the penalties of perjury, by a duly authorized representative of the pharmacy or pharmacy department and include;

(a) a sworn statement confirming that a complete inventory of controlled substances in Schedules II, III, IV and V signed by the outgoing pharmacist Manager of Record and the incoming pharmacist Manager of Record has been taken and filed with the pharmacy's controlled substance records. In the event the outgoing pharmacist Manager of Record is unavailable due to death, serious illness, or termination for inappropriate handling of controlled substances, a staff pharmacist may be authorized to sign the inventory, provided the Board is notified at the time the application is submitted why the staff pharmacist is signing the inventory;

(b) an application for a certificate of fitness (enclosed and or available on the Board's website), if applicable;

(c) the pharmacy permit and, if applicable, the pharmacy or pharmacy department's certificate of fitness (please do not return the controlled substance registration and or permit);

(d) required fee(s), a check or money order made payable in the proper amount to the "Commonwealth of Massachusetts"; and

(e) any additional information as determined by the Board.

For complete information regarding such regulations, please refer to 247 CMR 6.03(1). If additional information is necessary, please contact the Board office at (800) 414-0168.

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**APPLICATION FOR A CHANGE OF MANAGER**

I hereby apply for a permit to operate a store for the transaction of retail drug business in accordance with the provisions of Chapter 112, General Laws.

$351.00 licensure / application fee. Make check or money order for **$351.00** payable to the Commonwealth of Massachusetts. **This fee is non-refundable.**

1. Legal Name of Business._____

2. Full Business Address (Street Address, City, State and Zip)._____
   _____

3. Area Code and Telephone Number._____

4. All trade or business names ("D.B.A." names) used by same Corporation or by Licensee._____
   _____
   _____

5. Type of ownership or operation (i.e. sole proprietorship, partnership, corporation)._____
   _____
   If a corporation, please submit a copy of the Articles of Organization.

6. Name(s) and Social Security Number(s) of the owner(s) and/or operator(s) of the license.
   Please indicate type of ownership-Partnerships: the name of each partner and name and address of partnership; Corporations: the name and title of each corporate officer and director, the corporate names, name and address of parent company, if any, and the State of incorporation; Sole Proprietorships: the name of the sole proprietor and the name and address of the business entity.
   _____
   _____
   _____

7. Name of registered pharmacist previously charged with the management of the pharmacy.
   _____

8. Registration number of the previous manager._____

9. Name of registered pharmacist who is applying to manage the pharmacy._____

10. Registration number of the pharmacy manager applicant._____

11. Name(s) and registration number(s) of staff pharmacist(s) employed at pharmacy._____

12. Have any of the applicant(s) and/or managers-in-charge had: 1) any convictions related to the distribution of drugs (including samples); 2) any felony convictions; 3) any suspension(s) or revocation(s) or other sanction(s) by federal, state or local governmental agency of any license or registration currently or previously held by the applicant or license for the manufacture, distribution, or dispensing of any drugs, including controlled substances? Have any applications for licensure been denied by any federal or state agency including any state boards of pharmacy? List and explain. Attach additional sheets, if necessary.

13. A corporation or partnership which owns a pharmacy or pharmacy department which is registered by the Board shall notify the Board, within ten working days, in writing, of the following:

    (a) Any change in its Articles of Organization;

    (b) any change in its Foreign Corporate Certificate;

    (c) any change in the d/b/a name of the corporation accompanied by appropriate authorizing documentation;

    (d) any change in the names and addresses of its officers and/or directors, and/or in their positions; and

    (e) unless the stock of the corporation is publicly traded, any change in the total amount of stock issued or, names and addresses of the stockholders and the kinds and amounts of stock which they respectively own.

Affidavit (must be completed and notarized).

Pursuant to M.G.L. c. 62C, s. 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

The applicant certifies that each person employed in any prescription drug distribution activity has the education training, and experience, or any combination thereof, sufficient for that person to perform the assigned functions in such a manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law.

I hereby state that I am the person authorized to sign this application for all licensure; that all statements are true and correct in all respects and are made under the penalties of perjury.

_____

Signature of duly authorized representative of the pharmacy or pharmacy department

_____

Date

_____

Social Security Number of the proposed Manager of Record

Sworn and subscribed before me this_____day of _____

My commission expires_____ . _____

Name of Notary Public

TO BE COMPLETED BY THE BOARD: Check $_____ Date:_____ Number:_____